MDR Tracking Number: M5-05-0815-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-29-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, massage therapy and aquatic therapy were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 03-16-04 through 05-19-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 20th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO decision

January 14, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-0815-01
TWCC #:

Injured Employee:
Requestor: South Central Spine & Rehab
Respondent: Brownsville, I.S.D.
MAXIMUS Case #: TW04-0515

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. The patient reported that while at work she injured her right knee and both palms and low back when she fell after tripping in a hole. The initial diagnoses for this patient included lumbar HNP, contusion of right and left hands, internal knee derangement, knee sprain/strain. An MRI of the cervical spine performed on 12/23/03 showed disc desiccation and 2mm bulging at the C5-6 and C6-7 levels. On 3/16/04 the patient was evaluated for an exacerbation to her initial injury. Treatment for this patient's condition has included ultrasound, massage, aquatic therapy, electrical stimulation and medications.

Requested Services

Office visit, massage therapy, aquatic therapy, and office visit (99213) from 3/16/04 through 5/19/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Chronological Order of Case Management 12/10/03
2. Initial Report 12/10/03
3. Interim Report 3/16/04, 5/19/04
4. MRI report 10/14/02, 7/17/03, 12/23/03
5. Office Notes 4/19/04 – 5/19/04

Documents Submitted by Respondent:

1. Same as above

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a female who sustained a work related injury on ___. The MAXIMUS chiropractor reviewer indicated that the patient suffered an acute exacerbation of her ___ injury on or about ____. The MAXIMUS chiropractor reviewer noted that there were previous MRIs of the cervical and lumbar spine that showed a disc problem at C4-5 in 2002. The MAXIMUS chiropractor reviewer indicated that the patient now has lumbar L5-6 disc problems and that an MRI of the lumbar spine performed on 7/17/03 showed an L4-5 disc protrusion. The MAXIMUS chiropractor reviewer explained that this patient had problems with her neck and lumbar spine prior to her fall on ___. The MAXIMUS chiropractor reviewer also explained that the patient suffered a new trauma to the low back, knees and wrist that aggravated a preexisting condition. The MAXIMUS chiropractor reviewer further explained that the patient was most likely asymptomatic at the time of the injury. The MAXIMUS chiropractor reviewer indicated that treatment for the ___ injury would be considered medically necessary. The MAXIMUS chiropractor reviewer noted that the patient was treated for short periods of time and that her function and pain level improved with care and that she was able to continue working throughout her treatment. The MAXIMUS chiropractor reviewer explained that this patient's goals of care were met in a reasonable period of time with appropriate care of a multifaceted injury. The MAXIMUS chiropractor reviewer also explained that the type of care this patient received and her positive response was well documented.

Therefore, the MAXIMUS chiropractor consultant concluded that the office visit, massage therapy, aquatic therapy, and office visit (99213) from 3/16/04 through 5/19/04 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department